

# **HIPAA Provider Outreach Initiative for Vision Care**

by the  
**District of Columbia, Department of Health,  
Medical Assistance Administration**  
and the  
**HIPAA Provider Outreach Team**  
**June 9, 2003**

# Today's Agenda

- ▶ **HIPAA Overview**
- ▶ **New Vision Care Billing Policy**
- ▶ **Electronic Data Interchange**

# HIPAA Overview

# Objective

- ▶ **Overview**
  - ◆ **Administrative Simplification**
    - ▶ **Background**
    - ▶ **Goals**
    - ▶ **Benefits**
    - ▶ **HIPAA Rules**



# Background

- ▶ **Health Insurance Portability & Accountability Act**
  - ◆ **Portability**
    - ▶ **Insurance Reform**
  - ◆ **Accountability**
    - ▶ **Criminal and Civil Penalties**
  - ◆ **Administrative Simplification**
    - ▶ **Health Care Transactions and Code Sets**
    - ▶ **Privacy**
    - ▶ **Security**
    - ▶ **National Identifiers**

# Administrative Simplification

## ▶ Goals

- ◆ Increase the use and efficiency of electronic methods of exchanging standard health care information
- ◆ Reduce the number of forms, the methods of completing claims, and other health care related documents

# Administrative Simplification

## ► Benefits

- ◆ Lower administrative costs
- ◆ Enhance accuracy of data and reports
- ◆ Increase provider satisfaction
- ◆ Reduce processing time and improving cash management

# Administrative Simplification

<b>Regulation</b>	<b>NPRM Published</b>	<b>Final Rule Published</b>	<b>Compliance Deadline</b>
<b>Transactions &amp; Code Sets</b>	<b>05/07/98</b>	<b>08/17/00</b>	<b>10/16/03</b>
<b>Privacy</b>	<b>11/03/99</b>	<b>12/28/00</b>	<b>04/14/03</b>
<b>National Employer Identifier</b>	<b>06/16/98</b>	<b>05/31/02</b>	<b>07/30/04</b>
<b>Security</b>	<b>08/12/98</b>	<b>2/20/03</b>	<b>04/21/05</b>
<b>National Provider Identifier</b>	<b>05/07/98</b>		

# Administrative Simplification

Regulation	NPRM Published	Final Rule Published	Compliance Deadline
National Individual Identifier	<b>Not Published</b>		
National Health Plan Identifier			
Claims Attachment			
Enforcement	5/19/03- 5/24/03		

# Administrative Simplification

- ▶ **Standardized Transaction Sets**
  - ▶ **ANSI ASC X12N 837 = Health Care Claim (P, I, and D)**
  - ▶ **ANSI ASC X12N 835 = Health Care Claim Payment/Advice**
  - ▶ **ANSI ASC X12N 270 = Health Insurance Eligibility Request**
  - ▶ **ANSI ASC X12N 271 = Health Insurance Eligibility Response**
  - ▶ **ANSI ASC X12N 276 = Health Care Claims Status Inquiry**
  - ▶ **ANSI ASC X12N 277 = Health Care Claims Status Response**
  - ▶ **ANSI ASC X12N 278 = Health Care Claims Service Referral/Authorization**

# Administrative Simplification

## ▶ Code Sets

- ◆ **Nationally developed diagnosis and procedure codes**
  - ▶ **CPT, HCPCS, and ICD-9**
- ◆ **Non-medical code sets detailed in the implementation guides**
- ◆ **Must be used in all applicable standard transactions**
- ◆ **No local codes**

# Administrative Simplification

- ▶ **Privacy Rule-April 14, 2003**
  - ◆ **An individual's rights to control access and disclosure of their protected or individually identifiable health care information.**
  - ◆ **Objectives of the Privacy Rule:**
    - ▶ **Give patients more control**
    - ▶ **Establish appropriate safeguards**
    - ▶ **Hold violators accountable**



# Administrative Simplification

- ▶ **Security Rule-April 21, 2005**
  - ◆ **Designed to protect:**
    - ▶ **Confidentiality**
    - ▶ **Integrity**
    - ▶ **Availability**

# Administrative Simplification

## ▶ Identifiers

- ◆ **National Employer Identifier**
- ◆ **National Provider Identifier**
- ◆ **National Health Plan Identifier**
- ◆ **National Individual Identifier**

# Administrative Simplification

- ▶ **Centers for Medicare and Medicaid Services**
  - ◆ [www.cms.gov/hipaa/hipaa2/default.asp](http://www.cms.gov/hipaa/hipaa2/default.asp)
- ▶ **Office of Civil Rights**
  - ◆ [www.hhs.gov/ocr/index.html](http://www.hhs.gov/ocr/index.html)
- ▶ **Washington Publishing Company**
  - ◆ [www.wpc-edi.com/hipaa/HIPAA\\_40.asp](http://www.wpc-edi.com/hipaa/HIPAA_40.asp)
- ▶ **Workgroup for Electronic Data Interchange**
  - ◆ [www.wedi.org](http://www.wedi.org)

# QUESTIONS?

# New Vision Care Billing Policy

# Objective

**To briefly describe:**

- ▶ **New Vision Care Billing Policy**
- ▶ **HIPAA Review & Approval Process**
- ▶ **New Provider Inquiry Policy**

# Agenda

- ▶ **HIPAA Review and Approval Process**
- ▶ **New Vision Care Billing Policy**
  - ◆ **Overview**
- ▶ **CPT and HCPCS Crosswalk**
- ▶ **Claims Examples**
  - ◆ **Current Billing versus New Billing**
- ▶ **Transmittal Packet**
  - ◆ **How to read the Crosswalk Table**
  - ◆ **How to update your billing manual**
- ▶ **New Provider Inquiry Policy**

# HIPAA Review & Approval Process

## ▶ Six Step Process:

- ◆ HIPAA Business Analyst Review
- ◆ RHIA Analyst Review
- ◆ Registered Nurse Review
- ◆ MAA Subject Matter Expert Review
- ◆ Local Code Set Committee Review
- ◆ Approval by Interim Senior Deputy Director

## ▶ Result of Process:

- ◆ MAA Transmittal Letter

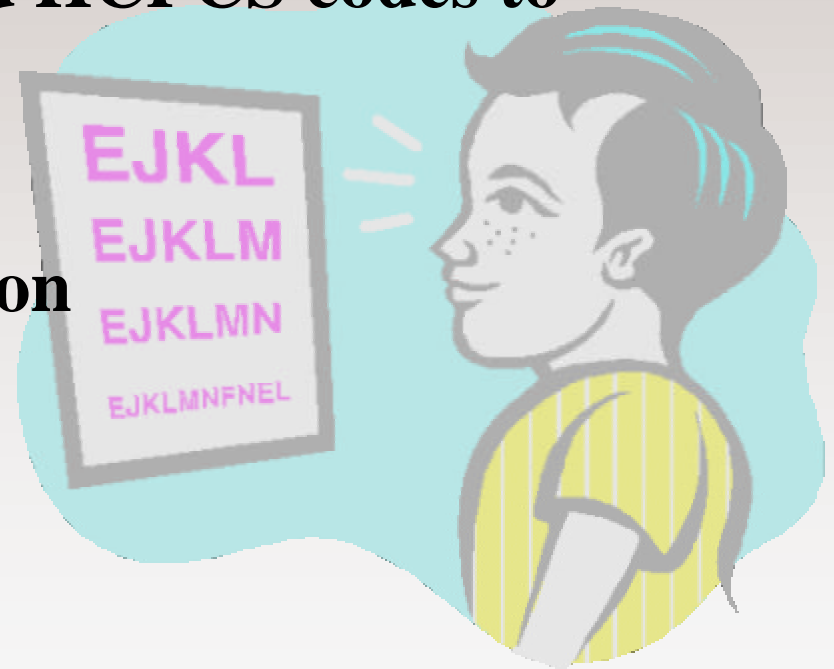




# New Vision Care Billing Policy

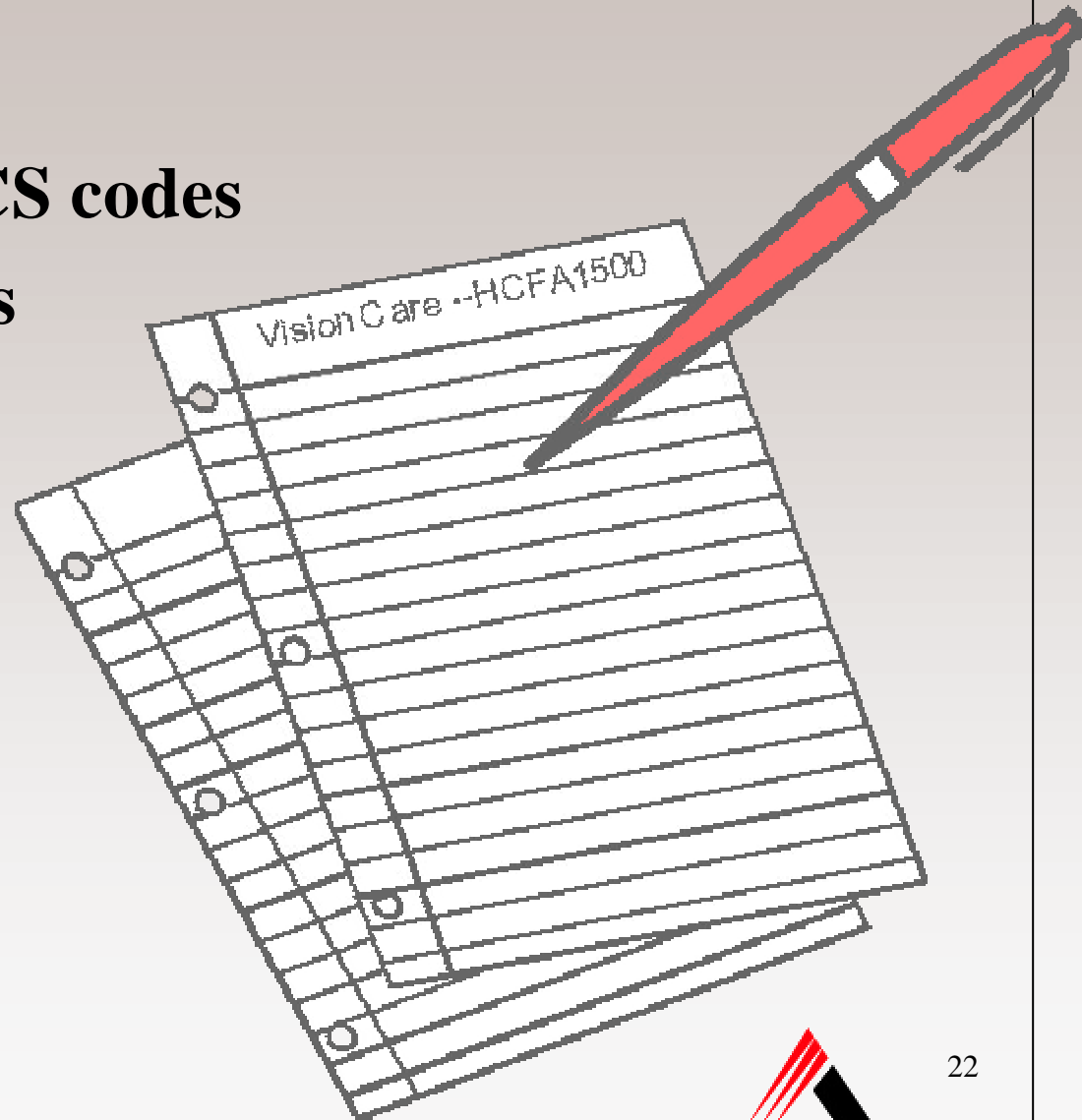
## ► Overview:

- ◆ **Effective date: August 1, 2003**
- ◆ **Use standard CPT and HCPCS codes to bill claims**
- ◆ **Do not attach outside lab/provider fabrication invoice to claim**
- ◆ **Keep invoices on file**



# New Vision Care Billing Policy

- ▶ **CPT and HCPCS codes**
  - ◆ **Examinations**
  - ◆ **Fittings**
  - ◆ **Frames**
  - ◆ **Lenses**



# CPT and HCPCS Crosswalk: Exams

## Current Code → Standard Code

### ▶ Opticians & Optometrists:

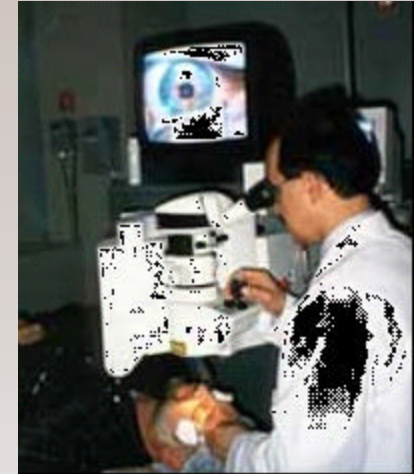
- ◆ Y2005 → 92015 –52
- ◆ Y2006 → 92015

### ▶ Ophthalmologists

- ◆ Y2005 → 92002, 92012, & 92014

### ▶ Code Definitions:

- ◆ Y2005 – visual examination (refraction)
- ◆ Y2006 – comprehensive exam
- ◆ 92015 – determination of refractive state
- ◆ 92002 – intermediate, new patient
- ◆ 92012 – intermediate, established patient
- ◆ 92014 – comprehensive, established patient, one or more visits



# New Vision Care Billing Policy: Fittings

## ▶ Repair/refittings

- ◆ Current Code → Standard Code

- ◆ Y2327 → 92370, 92371

- ◆ **Code Definitions:**

- ▶ Y2327 – service payment for replacement and or major repairs replacing lenses, templates or face plates, etc., adjusting them to the patient's face, including subsequent adjustments
- ▶ 92370 - repair/refit
- ▶ 92371 - repair/refit w/ prosthesis for aphakia



# New Vision Care Billing Policy: Fittings

## ▶ Lab Fabrication or Provider Fabrication:

### ◆ Current Code → Standard Code

◆ Y2340 or Y2344 → 92340

◆ Y2341 or Y2345 → 92341

◆ Y2342 or Y2346 → 92342



### ◆ Code Definitions:

- Y2340 - single vision services, fabricated by wholesale lab
- Y2341 - bifocal vision services, fabricated by wholesale lab
- Y2342 - trifocal vision services, fabricated by wholesale lab
- Y2344 - single vision services, fabricated by provider
- Y2345 - bifocal vision services, fabricated by provider
- Y2346 - trifocal vision services, fabricated by provider
- 92340 - monofocal provider or lab fabricated
- 92341 - bifocal provider or lab fabricated
- 92342 - trifocal provider or lab fabricated

# CPT and HCPCS Crosswalk: Frames

- ▶ **Frames - Single, Bifocal, & Trifocal**
  - ◆ **Current Policy:**
    - ▶ **Attach Invoice/Prescription to claim**
  - ◆ **New policy:**
    - ▶ **No Attachment**
    - ▶ **Standard Code: V2020**
- ▶ **Code Definition:**
  - V2020 - frames, purchases



# CPT and HCPCS Crosswalk: Lenses

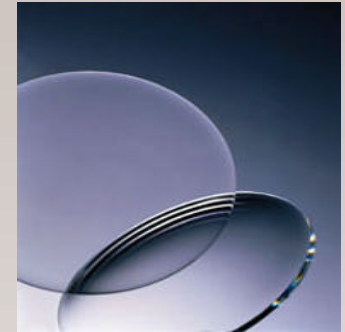
## ▶ Lenses

### ◆ Current Policy:

- ▶ Attach Invoice/Prescription to claim

### ◆ New Policy:

- ▶ No attachment
- ▶ Use standard codes for each lens type:
  - Single: V2100-V2199, and/or V2410
  - Bifocal: V2200-V2299, and/or V2430
  - Trifocal: V2300-V2399, and/or V2499
  - Contact Lenses: 92310



# CPT and HCPCS Crosswalk: Lenses

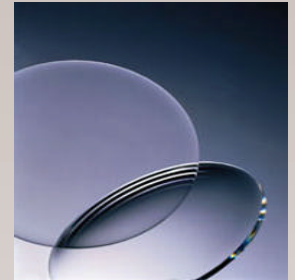
## ▶ Contact Lenses

### ◆ No Change in policy:

- Continue to obtain Prior Authorization
- Continue to use Standard Code: 92310

### ▶ Code Definition:

- 92310 - Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia)

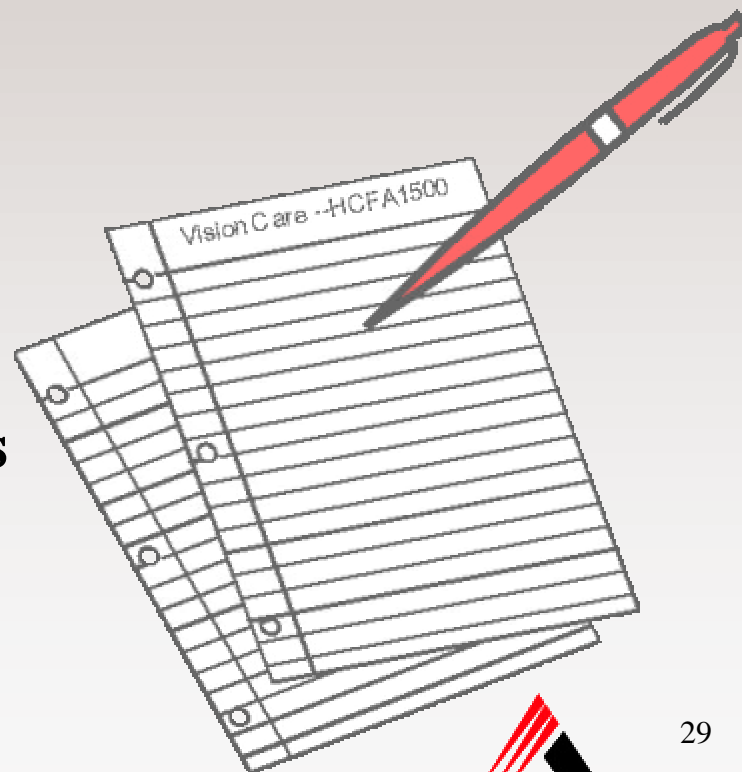




# Claims Examples

1. Lenses/Frames with Laboratory Fabrication
2. Lenses/Frames with Provider Fabrication
3. Lenses/Frames with Provider Fabrication including an Exam

- ▶ Real claims that are:
- ◆ PHI de-identified
  - ◆ Selected examples
  - ◆ Use provider billed charges (no relationship to current or new rates)



# Current Billing Frames & Lenses - Laboratory Fabrication

PLEASE DO NOT STAPLE IN THIS AREA

MEDICAID-DC  
P.O. BOX 34768  
ACS ATTN: CLAIMS DEPT.  
WASHINGTON, DC 20043

APPROVED OMB-0938-0008 109

## HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18. RESERVED FOR LOCAL USE

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A B C D E F G H I J K

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

32. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

SIGNED DATE

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-99) FORM RRB-1500 FORM QWCP-1500

## Custom Optical Lab

For WASHINGTON, D.C.

DATE PROMISED

INVOICE NO.

RECEIVED DATE

THAT NO.

BILLING DATE

PATIENT

SHL	CYL	AXIS	SECH. TRACTIONS	PRISM
R 75	+25	90		
L 50	+25	95		

Height	Width	Base
R M/M	M/M	L M/M

SECTORS WANTED	TOTAL	OTHER OPTIC	OTHER REFRACTION
RAYFIRE	UNITS	ORTH	FOV
OTHER		THAYER	

TECHNICAL SPECIALTY STYL

SHOUT FOR ---

INCH FOR ---

CASE HARDEN

OTHER LENS DETAIL

LENSES 30 05

FR. MTS 50 05

REPAIR

CASE

MISC.

TOTAL 50 05

SHOOTING INSTRUCTIONS

HOLDS PER LENS 1

STYLE, SIZE & COLOR OF FRAME OR MOUNTING

PARAGON 31

AND NEW SKIR

SIZE OF BRIDGE

SIZE OF TEMPLES

TYPE OF TEMPLES

# New Billing Frames & Lenses - Laboratory Fabrication

PLEASE DO NOT STAPLE IN THIS AREA

MEDICAID-DC  
P.O. BOX 34768  
ACS ATTN: CLAIMS DEPT.  
WASHINGTON, DC 20043

APPROVED OMB-0938-0008 103

## HEALTH INSURANCE CLAIM FORM

PICA ☐ PICA ☐

1. MEDICARE ☐ MEDICAID ☒ CHAMPUS ☐ CHAMPVA ☐ GROUP HEALTH PLAN (SSN or ID) ☐ FECA BLK LUNG (SSN) ☐ OTHER ☐ 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) ☐

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ☐ (Medicare #) ☐ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ 3. PATIENT'S BIRTH DATE ☐ SEX ☐ 4. INSURED'S NAME (Last Name, First Name, Middle Initial) ☐

5. PATIENT'S ADDRESS (No. Street) ☐ 6. PATIENT RELATIONSHIP TO INSURED ☐ 7. INSURED'S ADDRESS (No. Street) ☐

CITY ☐ STATE ☐ CITY ☐ STATE ☐

ZIP CODE ☐ TELEPHONE (Include Area Code) ☐ ZIP CODE ☐ TELEPHONE (Include Area Code) ☐

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) ☐ 10. IS PATIENT'S CONDITION RELATED TO: ☐ 11. INSURED'S POLICY GROUP OR FECA NUMBER ☐

9. OTHER INSURED'S POLICY OR GROUP NUMBER ☐ a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ 8. INSURED'S DATE OF BIRTH ☐ SEX ☐

10. OTHER INSURED'S DATE OF BIRTH ☐ SEX ☐ b. AUTO ACCIDENT? ☐ PLACE (State) ☐ 10. EMPLOYER'S NAME OR SCHOOL NAME ☐

11. EMPLOYER'S NAME OR SCHOOL NAME ☐ c. OTHER ACCIDENT? ☐ c. INSURANCE PLAN NAME OR PROGRAM NAME ☐

12. INSURANCE PLAN NAME OR PROGRAM NAME ☐ 10d. RESERVED FOR LOCAL USE ☐ d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ☐ DATE 07/12/2002 SIGNED ☐ SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (EMP) ☐ 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE ☐ 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION ☐

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE ☐ 17a. I.D. NUMBER OF REFERRING PHYSICIAN ☐ 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES ☐

19. RESERVED FOR LOCAL USE ☐ 20. OUTSIDE LAB? ☐ \$ CHARGES ☐

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) ☐

22. MEDICAID RESUBMISSION CODE ☐ ORIGINAL REF. NO. ☐

23. PRIOR AUTHORIZATION NUMBER ☐

24. A	B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) OPT/MCP/PCS I MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSON Family Plan	EMO	COB	RESERVED FOR LOCAL USE
12042001	12042001	11	92340	1	63.60	1				
12042001	12042001	11	V2020	1	20.00	1				
12042001	12042001	11	V2100 RT	1	15.00	1				
12042001	12042001	11	V2100 LT	1	15.00	1				

25. FEDERAL TAX I.D. NUMBER ☐ SSN ☐ EIN ☐ 26. PATIENT'S ACCOUNT NO. ☐ 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) ☐ 28. TOTAL CHARGE \$ 113.60 29. AMOUNT PAID \$ 0.00 30. BALANCE DUE \$ 113.60

31. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) ☐ 32. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE ☐

SIGNED ☐ DATE ☐ PIN# ☐ GPPI# ☐

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 888) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-99) FORM CWP-C-1500 FORM RRB-1500

**No Laboratory Invoice  
Attachment Needed  
(Keep on file)**

# Current vs. New Frames & Lenses - Laboratory Fabrication

**Current  
Local Codes**

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☒ YES ☐ NO \$ CHARGES 50.00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

24. A DATE(S) OF SERVICE B Place of C Type of D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR H I J K RESERVED FOR LOCAL USE  
MM DD YY MM DD YY Service Service MODIFIER

1	12042001	12042001	11	Y2340	1	63	60	1			
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO 28. TOTAL CHARGE \$ 63.60 29. AMOUNT PAID \$ 0.00 30. BALANCE DUE \$ 63.60

PHYSICIAN OR SUPPLIER INFORMATION

**Standard Codes  
Starting  
August 1, 2003**

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☒ YES ☐ NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

24. A DATE(S) OF SERVICE B Place of C Type of D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR H I J K RESERVED FOR LOCAL USE  
MM DD YY MM DD YY Service Service MODIFIER

1	12042001	12042001	11	92340	1	63	60	1			
2	12042001	12042001	11	V2020	1	20	00	1			
3	12042001	12042001	11	V2100 RT	1	15	00	1			
4	12042001	12042001	11	V2100 LT	1	15	00	1			

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO 28. TOTAL CHARGE \$ 113.60 29. AMOUNT PAID \$ 0.00 30. BALANCE DUE \$ 113.60

PHYSICIAN OR SUPPLIER INFORMATION

## Current Billing Lenses/Frames - Provider Fabrication

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

APPROVED CMB-0538-0008

X

I

IPICA

1. MEDICARE

(Medicare #)

MEDICAID

(Medicaid #)

CHAMPUS

(Sponsor's SSN)

CHAMPSA

(VA File #)

GROUP HEALTH PLAN (SSN or ID)

FECA BLK LUNG (SSN)

OTHER (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY

SEX

F

M

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

SAME SAME

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Set Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

SAME SAME

CITY WASHINGTON

STATE DC

ZIP CODE

TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

A. OTHER INSURED'S POLICY OR GROUP NUMBER

B. EMPLOYMENT (CURRENT OR PREVIOUS) YES NO

C. AUTO ACCIDENT? PLACE (State) YES NO

D. OTHER OCCIDENT? YES NO

E. INSURANCE PLAN NAME OR PROGRAM NAME

10c. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

SAME SAME

12. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY(LMP)

MM DD YY

13. EMPLOYER'S NAME OR SCHOOL NAME

N/A N/A

14. INSURANCE PLAN NAME OR PROGRAM NAME

MEDICAID MEDICAID

15. IF THERE ANOTHER HEALTH BENEFIT PLAN?

YES NO If yes, return to end and complete item 9-a-d.

16. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical claim or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

17. HOSPITALIZATION OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE UNDER FILE

DATE

18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

20. OUTSIDE LAB? \$ CHARGES

YES NO 321.55

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 367.1

2. \_\_\_\_\_

3. \_\_\_\_\_

22. MEDICAID SUBMISSION PRIOR ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE, FROM MM DD YY TO MM DD YY

B. Place of Service

C. Type of Service

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER

E. DIAGNOSIS CODE

F. \$ CHARGES

G. DATE EFFECTIVE ON OR Before

H. DAY OF Week

I. Family Plan

J. EMG

K. COR

L. RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Indicate any limitations/agreements on the reverse side.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SIGNED DATE

FORM QMS-1500 (12-99) FORM RFB-1500, FORM OWCP-1500 #50426 - Medical Arts Press Use with Enrollment #14146 (gummed) or #14146 (self-seal)

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**DEPARTMENT OF HUMAN SERVICES**  
**MEDICAID LABORATORY INVOICE FOR OPHTHALMIC DISPENSING, OPTION 11**  
 (This form is used only when eyewear is fabricated by the dispensing provider.)

**COMPLETE THIS FORM ACCURATELY AND SUBMIT WITH THE COMPLETED  
 D.C. MEDICAID HEALTH INSURANCE CLAIM FORM HCFA 1000.**

Patient's Name (Please Print) \_\_\_\_\_ Dispensing Provider's Name \_\_\_\_\_  
 \_\_\_\_\_  
 Name of Dispenser \_\_\_\_\_ Prescription File Number \_\_\_\_\_  
 2-11-03 \_\_\_\_\_  
 Date of Examination \_\_\_\_\_ Date of Service (Same as HCFA 1000) \_\_\_\_\_

**MATERIALS AND SERVICES PROVIDED**

FRAMES: ☒ Frame, Complete ☐ Use Patient's Frame ☐ Frame, Parts Only  
 Description of Frames \_\_\_\_\_  
 Page # from Catalog \_\_\_\_\_ Publication Date of Catalog \_\_\_\_\_  
 (Name of Frame) \_\_\_\_\_

LENS: \_\_\_\_\_  
 (Name of Firm from which lens blanks were purchased) \_\_\_\_\_  
 (Address) \_\_\_\_\_  
 WASHINGTON, D.C. \_\_\_\_\_

<input type="checkbox"/> GLASS LENSES	<input checked="" type="checkbox"/> SINGLE VISION	<input type="checkbox"/> SUPPLY CASES
<input checked="" type="checkbox"/> PLASTIC LENSES	<input type="checkbox"/> BIFOCAL	<input type="checkbox"/> TINT
<input type="checkbox"/> SAFETY LENSES	<input type="checkbox"/> TRIFOCAL	<input type="checkbox"/> OTHER

**PRESCRIPTION**

	SPH	CYL	AXIS	PRISM	BASE	IG	NP
RIGHT EYE	R	-4.25					
	L	-4.50					
LEFT EYE	R						
	L						

	ADDITION	BRIGHT	TYPE	WIDTH	SEMI WIDTH	SIZE, INCH	PD
RIGHT EYE	R						PAR
	L						NEAR

**SUMMARY OF CHARGES**  
 Actual Acquisition Cost

ITEM	COST
RIGHT LENS	
LEFT LENS	
1 PAIR	24.50
PRISM COMPLETE	
PRISM PARTIAL ONLY	8.00
PRISM TAMPLE FRONT	
PRISM TAMPLE LEFT	
OTHER	
<b>TOTAL CHARGE</b>	<b>32.50</b>

**CERTIFICATION:**  
 I certify that the costs listed above in the SUMMARY OF CHARGES are true and correct, and my laboratory's actual acquisition costs.

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_

# New Billing Lenses/Frames - Provider Fabrication

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED CMS-2008-0008

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA RAILROAD OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE, B. PLACE OF SERVICE, C. TYPE OF SERVICE, D. PROCEDURES, SERVICES, OR SUPPLIES, E. DIAGNOSIS CODE, F. \$ CHARGES, G. DAYS OF SERVICE, H. RESERVED FOR LOCAL USE

25. FEDERAL TAX ID NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE (888) PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90) FORM RRB-1500, FORM CWP-1500

1

**No Attachment Needed  
(Keep on file)**



# Current vs. New Lenses/Frames - Provider Fabrication

**Current  
Local Codes**

**Outside Lab** →

20. OUTSIDE LAB? ☐ YES ☒ NO \$ CHARGES 32 | 55

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)  
1. L367.1

24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSON Family Plan I EMG J COB K RESERVED FOR LOCAL USE

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
02	11	03	02	11	03	11	V2344		1	110	55	1																	

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (If gov't claim, see back) ☐ YES ☒ NO 28. TOTAL CHARGE \$ 110 | 55 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 110 | 55

PHYSICIAN OR SUPPLIER INFORMATION

**Standard Codes  
Starting  
August 1, 2003**

**Outside Lab** →

20. OUTSIDE LAB? ☐ YES ☒ NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)  
1. L367.1

24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSON Family Plan I EMG J COB K RESERVED FOR LOCAL USE

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
02	11	03	02	11	03	11	92340		1	78	01	1																	
02	11	03	02	11	03	11	V2020		1	8	00	1																	
02	11	03	02	11	03	11	V2101	RT	1	12	27	1																	
02	11	03	02	11	03	11	V2101	LT	1	12	27	1																	

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (If gov't claim, see back) ☐ YES ☒ NO 28. TOTAL CHARGE \$ 110 | 55 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 110 | 55

PHYSICIAN OR SUPPLIER INFORMATION

# Current Billing Lenses/Frames - Provider Fabrication - Exam

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

## HEALTH INSURANCE CLAIM FORM

1. MEDICARE ☐ MEDICAID ☒ CHAMPUS ☐ CHAMPVA ☐ GROUP HEALTH PLAN (SSN or ID) ☐ FECA (LUNG) (SSN or ID) ☐ OTHER ☐ (PICA) ☐

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]

3. PATIENT'S BIRTH DATE MM/DD/YY [REDACTED] SEX ☐ M ☐ F

5. PATIENT'S ADDRESS (No., Street) [REDACTED]

6. PATIENT STATUS ☐ Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street) [REDACTED]

8. PATIENT STATUS ☐ Single ☐ Married ☐ Other ☐

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) None

10. IS PATIENT'S COVERAGE RELATED TO: ☐ YES ☒ NO

11. INSURED'S POLICY GROUP OR FECA NUMBER Medicaid

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE [REDACTED] DATE 04-04-03

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE [REDACTED] DATE 04-04-03

14. DATE OF CURRENT ILLNESS (First symptom or injury (accident) or pregnancy) MM/DD/YY 04/04/03

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM/DD/YY 04/04/03

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY 04/04/03 TO MM/DD/YY 04/04/03

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE [REDACTED]

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY 04/04/03 TO MM/DD/YY 04/04/03

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO 146.95

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE 146.95

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE, FROM MM/DD/YY 04/04/03 TO MM/DD/YY 04/04/03 B. PLACE OF SERVICE 11 C. TYPE OF SERVICE Y2006 D. PROCEDURES, SERVICES, OR SUPPLIES (Broken Unusual Circumstances) CPT/ACCS, I MODIFIER 1 E. DIAGNOSIS CODE 1 F. \$ CHARGES 90 G. DAYS (EPOD) OR (Family Plan) - H. EMG - I. COB - J. RESERVED FOR LOCAL USE

25. FEDERAL TAX ID NUMBER [REDACTED] SSN EIN [REDACTED] 26. PATIENT'S ACCOUNT NO. [REDACTED] 27. ACCEPT ASSIGNMENT? (For gov. contracts, see back) ☐ YES ☒ NO

28. TOTAL CHARGE \$ 226.95 29. AMOUNT PAID \$ 0.00 30. BALANCE DUE \$ 226.95

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) [REDACTED] DATE 04-23-03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICE WAS RENDERED [REDACTED]

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE [REDACTED]

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 888) PLEASE PRINT OR TYPE FORM HCA-1500 (12-99) FORM OWCP-1500 FORM RRB-1500

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HUMAN SERVICES

## MEDICAID LABORATORY INVOICE FOR OPHTHALMIC DISPENSING, OPTION II

(This form is used only when eyeglasses are fabricated by the dispensing provider)

1. PROVIDER'S NAME (Please Print) [REDACTED] Dispensing Provider's Name [REDACTED]

2. PATIENT'S NAME (Please Print) [REDACTED] Prescription File Number [REDACTED]

3. DATE OF EXAMINATION 04-04-03 Date of Service (Same as HCFA 1500) 04-04-03

4. MATERIALS AND SERVICES PROVIDED

FRAMES ☒ Frame, Complete ☐ Lens Patient's Frame ☐ Frame, Parts Only

Description of Frame: Wellington Navigator 58114 (Date of Frame) [REDACTED]

Page # from Catalog [REDACTED]

LENS [REDACTED] (Name of Firm from which lens blanks were purchased) Dalhousie, Inc (Address) [REDACTED]

1. Glass Lenses ☒ Plastic Lenses ☐ Single Vision ☐ Multifocal ☐ Supply Case ☐ 1.1 Tint ☐ 1.2 Other ☐

2. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

3. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

4. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

5. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

6. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

7. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

8. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

9. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

10. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

11. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

12. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

13. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

14. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

15. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

16. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

17. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

18. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

19. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

20. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

21. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

22. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

23. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

24. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

25. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

26. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

27. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

28. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

29. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

30. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

31. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

32. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

33. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

34. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

35. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

36. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

37. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

38. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

39. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

40. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

41. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

42. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

43. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

44. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

45. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

46. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

47. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

48. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

49. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

50. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

51. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

52. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

53. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

54. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

55. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

56. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

57. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

58. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

59. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

60. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

61. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

62. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

63. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

64. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

65. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

66. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

67. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

68. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

69. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

70. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

71. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

72. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

73. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

74. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

75. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

76. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

77. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

78. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

79. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

80. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

81. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

82. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

83. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

84. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

85. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

86. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

87. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

88. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

89. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

90. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

91. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

92. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

93. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

94. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

95. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

96. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

97. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

98. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

99. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

100. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

101. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

102. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

103. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

104. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

105. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

106. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

107. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

108. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

109. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

110. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

111. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

112. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

113. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

114. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

115. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

116. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

117. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

118. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

119. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

120. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

121. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

122. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

123. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

124. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

125. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

126. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

127. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

128. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

129. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

130. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

131. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

132. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

133. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

134. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

135. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

136. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

137. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

138. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

139. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

140. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

141. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

142. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

143. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

144. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

145. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

146. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

147. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

148. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

149. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

150. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

151. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

152. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

153. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

154. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

155. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

156. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

157. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

158. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

159. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

160. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

161. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

162. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

163. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

164. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

165. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

166. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

167. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

168. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

169. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

170. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

171. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

172. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

173. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

174. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

175. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

176. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

177. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

178. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

179. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

180. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

181. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

182. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

183. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

184. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

185. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

186. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

187. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

188. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

189. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

190. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

191. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

192. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

193. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

194. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

195. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

196. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

197. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

198. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

199. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

200. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

201. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

202. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

203. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

204. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

205. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

206. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

207. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

208. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

209. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

210. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

211. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

212. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

213. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

214. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

215. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

216. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

217. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

218. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

219. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

220. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

221. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

222. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

223. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

224. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

225. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

226. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

227. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

228. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

229. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

230. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

231. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

232. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

233. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

234. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

235. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

236. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

237. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

238. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

239. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

240. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

241. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

242. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

243. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

244. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

245. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

246. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

247. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

248. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

249. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

250. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

251. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

252. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

253. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

254. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

255. Single Vision ☐ Multifocal ☐ Tinted ☐ Other ☐

256. Single Vision



# New Billing Lenses/Frames - Provider Fabrication - Exam

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

APPROVED OMB-0638-0008

HEALTH INSURANCE CLAIM FORM										PICA <input type="checkbox"/>
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BLACK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		(Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID) <input type="checkbox"/> (RD) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM / DD / YY		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No. Street)				6. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street)				
CITY <u>Washington</u>		STATE <u>DC</u>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY <u>Washington</u>		STATE <u>DC</u>		
ZIP CODE <u>20000</u>		TELEPHONE (Include Area Code) <u>(202) 336-1100</u>		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		ZIP CODE <u>20000</u>		TELEPHONE (INCLUDE AREA CODE) <u>(202) 336-1100</u>		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <u>None</u>				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) <u>DC</u> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR PROGRAM NUMBER <u>medicaid</u>				
a. OTHER INSURED'S DATE OF BIRTH MM / DD / YY <u>MM / DD / YY</u> SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>				b. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME <u>medicaid</u>				
d. INSURANCE PLAN NAME OR PROGRAM NAME				10c. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9-d.				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED <u>[Signature]</u> DATE <u>04-04-03</u>					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED <u>[Signature]</u>					
14. DATE OF CURRENT: <u>04-04-03</u> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (CLMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM / DD / YY					
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 21E BY LINE) 1. <u>L51.2 0</u>					22. MEDICARE RESUBMISSION CODE <u>3</u> ORIGINAL REF. NO.					
2. <u>L36.1</u>					23. PRIOR AUTHORIZATION NUMBER					
24. A DATE(S) OF SERVICE From MM / DD / YY To MM / DD / YY B Place of Service C Type of Service D					E DIAGNOSIS CODE					
1. <u>04-04-03 04-04-03 11</u>					1. <u>92015</u>					
2. <u>04-04-03 04-04-03 11</u>					2. <u>V2200</u>					
3. <u>04-04-03 04-04-03 11</u>					3. <u>V2200 RT</u>					
4. <u>04-04-03 04-04-03 11</u>					4. <u>V2200 LT</u>					
5. <u>04-04-03 04-04-03 11</u>					5. <u>V2200</u>					
6. <u>04-04-03 04-04-03 11</u>					6. <u>V2200</u>					
7. <u>04-04-03 04-04-03 11</u>					7. <u>V2200</u>					
8. <u>04-04-03 04-04-03 11</u>					8. <u>V2200</u>					
9. <u>04-04-03 04-04-03 11</u>					9. <u>V2200</u>					
10. <u>04-04-03 04-04-03 11</u>					10. <u>V2200</u>					
11. <u>04-04-03 04-04-03 11</u>					11. <u>V2200</u>					
12. <u>04-04-03 04-04-03 11</u>					12. <u>V2200</u>					
13. <u>04-04-03 04-04-03 11</u>					13. <u>V2200</u>					
14. <u>04-04-03 04-04-03 11</u>					14. <u>V2200</u>					
15. <u>04-04-03 04-04-03 11</u>					15. <u>V2200</u>					
16. <u>04-04-03 04-04-03 11</u>					16. <u>V2200</u>					
17. <u>04-04-03 04-04-03 11</u>					17. <u>V2200</u>					
18. <u>04-04-03 04-04-03 11</u>					18. <u>V2200</u>					
19. <u>04-04-03 04-04-03 11</u>					19. <u>V2200</u>					
20. <u>04-04-03 04-04-03 11</u>					20. <u>V2200</u>					
21. <u>04-04-03 04-04-03 11</u>					21. <u>V2200</u>					
22. <u>04-04-03 04-04-03 11</u>					22. <u>V2200</u>					
23. <u>04-04-03 04-04-03 11</u>					23. <u>V2200</u>					
24. <u>04-04-03 04-04-03 11</u>					24. <u>V2200</u>					
25. FEDERAL TAX I.D. NUMBER <u>SSN</u> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					26. PATIENT'S ACCOUNT NO.					
27. ACCEPT ASSIGNMENT? (For gov't. clinics, line back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					28. TOTAL CHARGE \$ <u>236.95</u>					
29. AMOUNT PAID \$ <u>50.00</u>					30. BALANCE DUE \$ <u>236.95</u>					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  DATE <u>04-03-03</u>					32. NAME AND ADDRESS OF FACILITY WHERE SERVICE WAS RENDERED					
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE					34. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE					

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE B-88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)  
FORM OWCP-1500 FORM RRB-1500

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

1

**No Attachment Needed  
(Keep on file)**

# Current vs. New Lenses/Frames - Provider Fabrication - Exam

**Current  
Local Codes**

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO \$ CHARGES 146 95

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. LV320

2. L3631

3. L

4. L

24. A	B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From To MM DD YY MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
04 04 03 04 04 03	11		V2006	1	80 -					
04 04 03 04 04 03	11		V2345	2						
04 04 03 04 04 03	11		lab invoice attached	2	146 95					

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☒ NO 28. TOTAL CHARGE \$ 226 95 29. AMOUNT PAID \$ - 0 - 30. BALANCE DUE \$ 226 95

PHYSICIAN OR SUPPLIER INFORMATION

**Standard Codes  
Starting  
August 1, 2003**

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. L3671

3. L

4. L

24. A	B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From To MM DD YY MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
02 11 03 02 11 03	11		92340	1	78 01	1				
02 11 03 02 11 03	11		V2020	1	8 00	1				
02 11 03 02 11 03	11		V2101 RT	1	12 27	1				
02 11 03 02 11 03	11		V2101 LT	1	12 27	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☒ NO 28. TOTAL CHARGE \$ 110 55 29. AMOUNT PAID \$ - 0 - 30. BALANCE DUE \$ 110 55

PHYSICIAN OR SUPPLIER INFORMATION

# **New Vision Care Billing Policy - Summary**

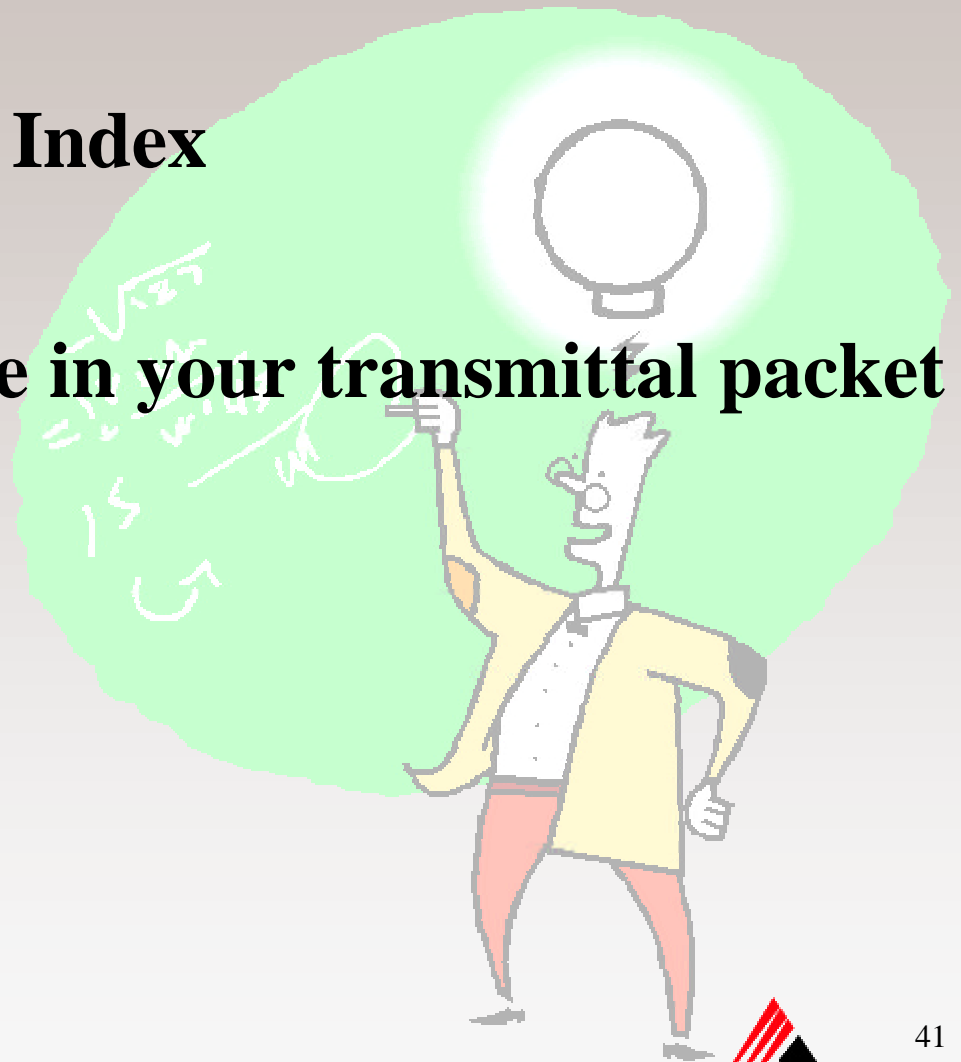
- ▶ **Transition Date: August 1, 2003**
- ▶ **Do not submit invoices/prescriptions as an attachment to your claim**
- ▶ **Keep invoices/prescriptions on file**
- ▶ **Use Standard Codes (refer to Crosswalk Table)**

# Transmittal Packet—Crosswalk Table

Local Code & Modifier Description	Standard Code Description	Medicaid Rates	Remarks
Y2005  VISUAL EXAMINATION - REFRACTION	92015 -52  Determination of refractive state. The examiner determines the prescription required by evaluating the effectiveness of a series of lenses through which the pt is asked to view an eye chart. Physician not required to be present. A prescription is issued, no fitting is done at this time.	No Pricing Change	Optician and optometrist will bill this code for visual examination.

# Transmittal Packet—Billing Manual

- ▶ **Added a Revision Index**
- ▶ **Updated pages are in your transmittal packet**

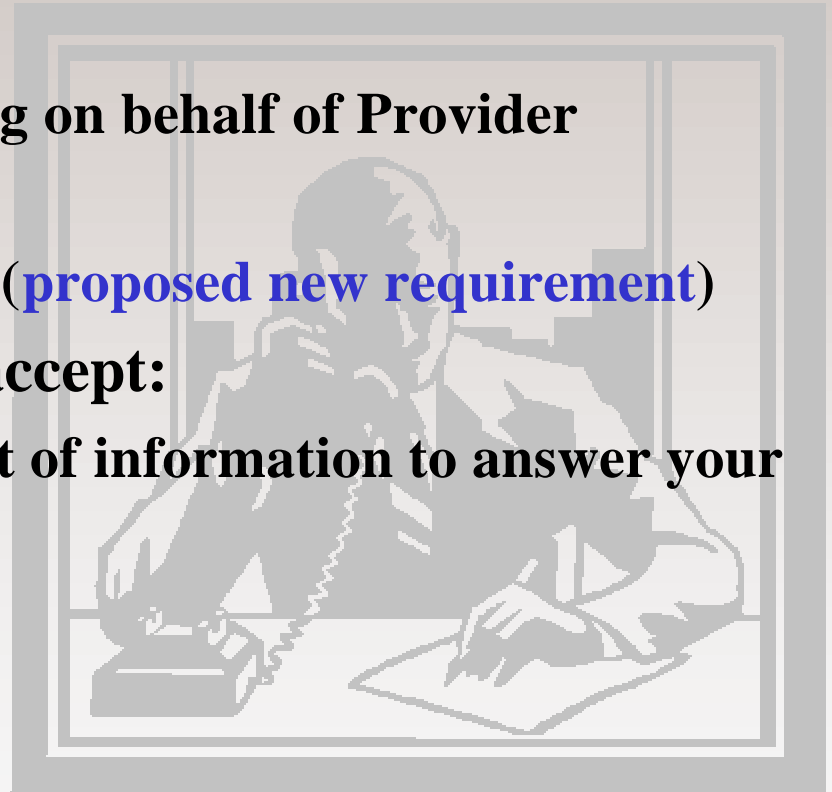


# Billing Manual Update - Revision Index

Revision Reference				
Section	Remove Page	Insert Page	Revised Page(s)	Description of Change
Billing Manual Cover Page	N/A	Not numbered	New	§ Added standard Billing Manual cover page.
Table of Contents	N/A	2-6	New	§ Added Table of Contents.
Table of Contents	N/A	7	New	§ Insert Revision Index page, Revised Date of 05/03/03.
Section 8.8	50	50	50	§ Added paragraph requesting provider name, tax id, provider Medicaid number, and name of person making call.
Section 13.5	68-69	68-69	68-69	§ Removed references to submitting attachments for Option I, Option II § Added instructions for billing frames, lenses, and fittings using standard HCPCS codes
Section 13.6	72	72	72	§ Removed references to submitting attachments for Option I, Option II § Added instructions for billing frames, lenses, and fittings using standard HCPCS codes
Section 13.8	85	85	85	§ Removed reference to Option I and Option II for Block 20.

# New Provider Inquiry Policy

- ▶ **When Calling the Provider Inquiry Unit**
  - ◆ **Please be prepared to provide:**
    - ▶ **Provider Name**
    - ▶ **Name of person calling on behalf of Provider**
    - ▶ **Medicaid Provider ID**
    - ▶ **Provider Tax ID/SSN (**proposed new requirement**)**
  - ◆ **Please be prepared to accept:**
    - ▶ **The minimum amount of information to answer your inquiry**



# Provider Inquiry Unit

- ▶ **Hours of operation:**
  - ▶ **Monday through Friday**
  - ▶ **8 A.M. until 5 P.M.**
  
- ▶ **Telephone number: (866) 752-9233**
  
- ▶ **Correspondence address:**
  - ▶ **ACS**
  - ▶ **Attention: Provider Inquiry Unit**
  - ▶ **P.O. Box 34734**
  - ▶ **Washington, DC 20043-4761**



# Provider Outreach Training Schedule

- ▶ **Introductory – June 9, 2003**
  - ◆ Thank you, for attending today's training. ☺
  
- ▶ **Detailed - June 16 – July 18, 2003**
  - ◆ Electronic Claims Companion Guides
  
- ▶ **Software - Aug 1 – Aug 31, 2003**
  - ◆ WINASAP2003

# Questions?



# Electronic Data Interchange

**ACS EDI Gateway, Inc.**

# Purpose

- ▶ **To provide an overview of**
  - ◆ **ACS EDI Gateway, Inc**
    - ▶ **Trading Partner Management**
      - Enrollment process
      - Community outreach
      - EDI Support Unit

# Trading Partner Management

- ▶ **Enrollment Packets**
  - ◆ **Enroll through EDI Gateway, Inc. via:**
    - ▶ **EDI Enrollment Packet**
      - Demographics and contact information
      - Submission methods
      - Transactions
      - Response Retrieval
    - ▶ **Obtain via:**
      - ACS EDI Support Unit at 866.775.8563, Monday through Friday, 8 a.m. to 5 p.m. EST
      - Download from website [www.acs-gcro.com](http://www.acs-gcro.com)

# Trading Partner Management

- ▶ **EDI Provider Enrollment Packet**
  - ◆ **Individual**
  - ◆ **Group**

# Trading Partner Management

- ▶ **EDI Submitter Enrollment Packet**
  - ◆ **Software Vendor**
  - ◆ **Billing Agent**
  - ◆ **Clearinghouse**

# Trading Partner Management

- ▶ **Community Outreach**
  - ◆ **ACS EDI Gateway Business Analysts**
    - ▶ **Training**
      - Services
      - Software
    - ▶ **Research Issues**
      - Format/reject related issue



# Trading Partner Management

- ▶ **Community Outreach**
  - ◆ **Companion Guides**
    - ▶ **Data clarification**
    - ▶ **ASC X12N Transaction Set Implementation Guides**
  - ◆ **Testing**
    - ▶ **Established testing strategy and process**
    - ▶ **Reduces number of invalid transactions**
    - ▶ **Mitigates fraud and abuse risk**
    - ▶ **Approved vendors**

# Trading Partner Management

- ▶ **Community Outreach**
  - ◆ **ACS EDI Gateway Support Unit**
    - ▶ **Technical assistance with software, hardware, and transmission issues**
    - ▶ **Data Exchange Services**
    - ▶ **Informational Services**
    - ▶ **Enrollment of submitters**
    - ▶ **866.775.8563, Monday through Friday, 8 a.m. to 5 p.m. EST**

# Trading Partner Management

- ▶ **Call ACS EDI Support Unit**
  - ◆ **866.775.8563**
    - ▶ **Request ACS EDI Gateway Trading Partner Enrollment Packets**
    - ▶ **Verify status of EDI Trading Partner Enrollment Forms**
    - ▶ **Request logon information**
    - ▶ **Verifying confirmation receipt for electronic claims submission**

# Trading Partner Management

- ▶ **Call ACS EDI Support Unit**
  - ◆ **866.775.8563**
    - ▶ **Download, install, and train on WINASAP2003 software**
    - ▶ **Retrieve electronic responses via iDEx**
    - ▶ **Remedy electronic transmission difficulties**

# Trading Partner Management

- ▶ **When to call Provider Inquiry**
  - ◆ **866.752.9233**
    - ▶ **Billing questions related to policy**
    - ▶ **Electronic Funds Transfer (EFT)**
    - ▶ **Paper claims processing**
    - ▶ **Medicaid program enrollment**

# QUESTIONS?



**This presentation may contain “forward-looking statements” within the meaning of the Private Securities Litigation Reform Act of 1995. These statements are subject to numerous risks and uncertainties, many of which are outside the Company’s control. As such, no assurance can be given that the actual events and results will not be materially different than the anticipated results described in the forward-looking statements. Factors could cause actual results to differ materially from such forward-looking statements. For a description of these factors, see the Company’s prior filings with the Securities and Exchange Commission, including the most recent Form 10-K. ACS disclaims any intention or obligation to revise any forward-looking statements, whether as a result of new information, future event, or otherwise.**